C-253.8 Medicaid/Medicare Coinsurance

= Beginning October 1, 2005, when a resident is receiving Medicare Part A Skilled Nursing Facility benefits, the coinsurance amount paid by the Department, if any, will be the amount the Medicaid rate exceeds the amount Medicare would actually pay for the specific resident's care, not the coinsurance per diem amount in effect at the time. This amount will also be reduced by any resident income available to be applied to the cost of care. Any resident that is QMB eligible will not be responsible for applying their income towards the cost of care during the Medicare coinsurance coverage period.

The local office group care worker must be contacted for each resident who returned to the facility but received 100% coverage due to Medicare Part A Skilled Nursing Facility benefit so the appropriate category of service is updated on the long term care system. When a resident enrolled in Medicare is admitted to a Medicare certified bed, the facility is to submit to the Medicare intermediary the required form in order to obtain information regarding the resident's entitlement to SNF services. When information is received regarding eligibility, number of days, and amount of coinsurance obligation, the facility has responsibility for notifying the local office group care worker of the information obtained on Form DPA 1156 (See Appendix C-10). If appropriate, the group care worker will prepare Form DPA 2449 (See Appendix C-20) to effect the coinsurance authorization. If Medicare benefits are denied, the facility must inform the local office group care worker of the date the resident was readmitted to the facility.

Payment is made for long term care facility services after services have been provided.

The Bureau of Long Term Quality Care has established separate and distinct payment policy and procedures for:

1. Long term care services included in the cost-related reimbursement system, (see Topic C-253),

2. Exceptional Care Program, (see Topic C-253.6),

3. Oxygen Services, (see Topic C-244),

4. Therapy Services, (see Topic C-243),

5. Nurses' Aid Training and Competency Testing, (see Topic C-245),

6. Developmental Training Program, (see Topic C-253.5),

7. Active Treatment, (see Topic C-253.7), and

8. Medicare/Medicaid Coinsurance, (see Topic C-253.8).

## C-260 PAYMENT

### C-261 Authorization For Payment

The first step in the payment process is authorization for payment. Payment can be made only for those residents for whom a completed Form DPA 2299, Long Term Care Authorization, has been data entered into the Department's computer system. A copy of the completed form is provided to the facility (see Appendix C-19). Authorization for payment cannot be completed until resident eligibility is established; and the facility has provided the Group Care Worker with copies of forms: DPA 2536, Interagency Certification of Determination of Screening Assessment Results For Long Term Care, DPA 2448, Physician Certification and DPA 26, Report on Resident of Private Long Term Care Facility. (See Appendix C-8, C-9, and C-11)

All forms pertaining to processing group care actions for foster children (Forms DPA 2248, DPA 1156, DPA 26 and any required screening forms) need to be forwarded by the LTC facility to:

DCFS Determination Unit
406 East Monroe
Station 422
Springfield, Illinois 62701-1498
(217) 785-2554

After information from the Form DPA 2299 has been entered into the computer by local office, computer generated Form DPA 2449, LTC Update Authorization Document, is issued to the Group Care Worker. Form DPA 2449 is a turnaround document which is used by the Group Care Worker to report changes in level of care and patient credit amounts and to report death/discharge dates.

All facilities are requested to keep the caseworker advised of changes on a timely basis utilizing Form DPA 1156 (see Appendix C-10) to enable the local office to data enter all change actions as a single transaction.

### C-261.1 Reserve Bed Authorization

As reserve bed periods occur, the facility administrator or designated employee (designated as having limited power of attorney)is to submit Form DPA 2234, Bed Reserve Form (see Appendix C-1), for each resident in the facility for whom a bed was reserved for one or more days of the service period while the resident was absent from the facility. Data must be updated on the Recipient Data Base, if appropriate, to account for each day of the service period. See Topic C-231 for reserve bed policy.